STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155501	A. BUILDING 01 B. WING	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVALE HEALTH AND REHABILITATION CENTER	1529 W LANCASTER ST BLUFFTON, IN46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000		K0000		

A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 04/07/11

Facility Number: 000465
Provider Number: 155501
AIM Number: 100273870

Surveyor: Amy Kelley, Life Safety Code Specialist

At this Life Safety Code survey, Meadowvale Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This one story facility was determined to be of Type V (111) construction and was fully

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 120 and had a census of 68 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/12/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4			
SS=E	Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance	K0025	**K – 025** It is the practice of this facility to assure that all miscellaneous life safety issues are within compliance at all times to include: 1. The Maintenance Supervisor	05/23/2011

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	rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any residents in the center 500 hall and at the center nurses' station in the event of an emergency. Findings include: Based on an observation with the Maintenance Director on 04/07/11 at 2:45 p.m., there is a one and one fourth inch unsealed penetration in the ceiling at the fire doors near resident room 502 where new computer lines were run. Measurements were provided by the Maintenance Director at the time of observation. 3.1-19(b)		will patch the one and one fourth inch unsealed penetration in the ceiling at the fire doors near resident room 502 with a fire retardant sealant. 2. An audit was conducted by the Maintenance Supervisor to identify and repair any smoke barriers to ensure there will be continuous form from outside wall to an outside wall. 3. The Maintenance Supervisor was in-serviced on April 14, 2011 on Life Safety Tag K025 to identify unsealed penetration in the ceilings of the facility. 4. An audit will be conducted by the Maintenance Supervisor on a monthly basis in order to identify any unsealed penetrations. It will also be monitored through the facility's Performance Improvement Program for further recommendations and resolutions.	
K0038	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1			
SS=E	Based on observation and interview, the facility failed to ensure 1 of 8 exit discharge paths	K0038	**K – 038** It is the practice of this facility to assure that all miscellaneous life safety issues	05/23/2011

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	was readily accessible at all times. This deficient practice could affect any residents evacuated through the 600 north hall exit in the event of an emergency. Findings include: Based on observation with the Maintenance Director and the Regional Facility Manager on 04/07/11 at 12:22 p.m., according to a sign on the 600 north exit door, the magnetic lock will release after the crash bar is held for fifteen seconds. The magnetic lock did not release after the crash bar was held for forty five seconds. Based on an interview with the Maintenance Director at the time of observation, he could not determine why the magnetic lock did not release and he was able to make a temporary fix until the fire alarm company is contacted to make the repair. 3.1-19(b)		are within compliance at all times to include: 1. The Maintenance Supervisor had a contractor come to the facility and adjust the magnets on the 600 hall egress door. 2. An audit of the exit discharge paths will be monitored by the Maintenance Supervisor on a weekly basis to ensure resident safety. 3. The Maintenance Supervisor was in-serviced on April 14, 2011 on Life Safety Tag K038 to ensure the exit discharge paths will release after 15 seconds. 4. An audit will be conducted by the Maintenance Supervisor on a weekly basis in order to ensure the discharge paths are accessible. It will also be monitored through the facility's Performance Improvement Program for further recommendations and resolutions.	
K0046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and record	K0046	**K – 046** It is the practice of this	05/23/2011

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	review, the facility failed to ensure 1 of 1 emergency lights was tested annually for at least a 1 1/2 hour duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency light for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director and the Regional Facility Manager on 04/07/11 at 1:30 p.m., a battery operated emergency light was observed at the generator. During record review with the Maintenance Director at 11:50 a.m., no written record of an annual test regarding the battery operated emergency light was available for review.		facility to assure that all miscellaneous life safety issues are within compliance at all times to include: 1. The Maintenance Supervisor tested the emergency lights on April 4, 2011 for one and one-half hour duration. 2. The Maintenance Supervisor will keep a written record of a time and date in which the battery operated emergency light will be tested annually. 3. The Maintenance Supervisor was in-serviced on April 14, 2011 on Life Safety Tag K046 to ensure the battery operated emergency lights will be tested annually. 4. An audit will be conducted by the Maintenance Supervisor on an annual basis in order to ensure the battery operated emergency lights are fully operational. It will also be monitored through the facility's Performance Improvement Program for further recommendations and resolutions.	

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	3.1-19(b)			
K0144	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.			
SS=F	Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and	K0144	**K – 144** It is the practice of this facility to assure that all miscellaneous life safety issues are within compliance at all times to include: 1. The Maintenance Supervisor had a contractor come to the facility and evaluate the emergency generator for installation of a remote manual stop. 2. The Maintenance supervisor has made the necessary contact for the contractor to come out and ensure compliance by installing a remote manual stop. 3. The Maintenance Supervisor was in-serviced on April 14, 2011 on Life Safety Tag K144 to ensure that the emergency generator would need a remote manual stop. 4. All necessary contracted work has been contracted; facility is waiting for work to be accomplished.	05/23/2011

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	from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director, Regional Facility Manager and the Executive Director on 04/07/11 during a tour of the facility from 12:22 p.m. to 2:45 p.m., the facility did not have a remote manual stop for the emergency generator. Based on an interview with the Maintenance Director at 11:45 a.m., the generator engine was rated 107 horsepower. 3-1.19(b)			